MEDICAL CLEARANCE REQUEST
STATE OF MICHIGAN
Department of Human Services
Office of Children and Adult Licensing

REQUESTER INFORMATION: (To be Completed by Licensing Consultant)

Facility/Home Name		Tracking/License Number	
Facility/Home Address (Street Number and Name)	City	State	Zip Code

Licensing Consultant (Name, Address, Phone)

PLEASE MAIL TO ➡

License Application Type
- ☐ Adult Foster Care (24-Hour Care)
- ☐ Child Foster Care (24-Hour Care)
- ☐ Child Day Care (Less Than 24-Hour Care)
- ☐ Capacity _____

PATIENT INFORMATION (To be Completed by Patient) [Please Print or Type]

Name (Last, First, Middle, Jr., II, etc.)	Date of Birth	Social Security Number	Phone Number
Address (Street Number and Name)	City	State	Zip Code

RELEASE OF INFORMATION (To be Completed by Patient)

I authorize the release of medical information concerning me to the care facility listed above and to the Department of Human Services, Office of Children and Adult Licensing, for the purpose of determining my suitability to provide or be associated with the care of children/dependent adults.

Date

Patient's Signature

Physician's Name (Please PRINT or TYPE)

MEDICAL INFORMATION (To be Completed by Physician)

- **This individual is, or will be, employed in a child/dependent adult care setting.**
- **It is necessary to establish that those providing care are in such physical and mental condition and health as not to adversely affect the health or safety of a child/dependent adult and the quality and manner of his/her care.**
- **To assist us in this determination, you are being asked to answer the following.**

Has this Person Been Tested for T.B.?	Date Tested	Test Type	Results
☐ NO ☐ YES If Yes ➡		☐ Skin Test ☐ X-Ray	☐ Positive (Explain in Comments) ☐ Negative

How would you describe the patient's general physical/mental condition and health? (Use Comments section for explanations)
- ☐ No physical/mental condition or health problem exists that would limit the ability to work with or around children/dependent adults.
- ☐ Physical/mental condition or health problem exists that would not limit the ability to work with or around children/dependent adults. Explain in Comments if reasonable accommodation may be needed.
- ☐ Physical/mental condition or health problem exists which would affect the ability to work with or around children/dependent adults, with or without reasonable accommodation.

Comments (Please use back of this form if additional space is needed.)

Would you like to be contacted by the licensing consultant regarding your recommendation? ☐ Yes ☐ No

Physician's Signature	Signature Date	Telephone Number	Examination Date
Address (Street Number and Name)	City	State	Zip Code

AUTHORITY: Public Act 116 of 1973 as amended
Public Act 218 of 1979 as amended
RESPONSE: Voluntary
PENALTY: Application for licensure may be denied.

The Department of Human Services (Department of Human Services) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your county.